DELINEATION OF CLINICAL PRIVILEGES - DIAGNOSTIC RADIOLOGY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Category 1. Includes: (1) practitioners who have successfully completed a diagnostic radiology residency in an accredited program and are not board certified; and (2) practitioners, even if board certified, who have not received training in a subspecialty area. Under this category the practitioner may practice in an area of subspecialty, but must obtain consultation unless doing so would endanger the survival or well being of the patient.

Requested	Approved	
		Category I clinical privileges

Category II. Includes practitioners who are board certified by the American Board of Radiology, or its equivalent, that have not received fellowship training in a subspecialty area, but have received limited training during residency. Practitioners who once qualified in Category III, but are no longer clinically active in a particular subspecialty field, will receive Category II privileges. Under this category, practitioners may perform and/or interpret subspecialty procedures but must request radiological consultation when the diagnosis is in doubt or if the examination is not successful.

Requested	Approved	
		Category II clinical privileges

Category III. Includes practitioners who have specialty board certification granted by the American Board of Radiology, or its equivalent, and who practice in a subspecialty area that requires completion of fellowship training in that subspecialty field. Members in this category may perform procedures and interpret them on a full-time basis without radiological consultation.

Requested	Approved	
		Category III clinical privileges

Specific Privileges

Requested	Approved	
		a. Diagnostic Angiography (Specify: neuro, body, or both)
		b. Ultrasonography to include percutaneous needle biopsies of abdominal organs and cyst punctures
		c. Neuroradiology
		d. Interventional radiology
		e. Computerized Axial Tomography (CAT)
		f. Magnetic Resonance Imaging (MRI)
		g. Mammography to include breast ultrasound and percutaneous needle biopsies
		h. Hysterosalpingogram
		i. Arthrogram
		j. Myelogram
		k. Venogram
		l. Other *(Specify)*

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - DIAGNOSTIC RADIOLOGY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PRIVILEGE CATEGORY	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	Category I clinical privileges			
	Category II clinical privileges			
	Category III clinical privileges			
	Specific Privileges			
	a. Diagnostic Angiography (Specify: neuro, body, or both)			
	b. Ultrasonography to include percutaneous needle biopsies of abdominal organs and cyst punctures			
	c. Neuroradiology			
	d. Interventional radiology			
	e. Computerized Axial Tomography (CAT)			
	f. Magnetic Resonance Imaging (MRI)			
	g. Mammography to include breast ultrasound and percutaneous needle biopsies			
	h. Hysterosalpingogram			
	i. Arthrogram			
	j. Myelogram			
	k. Venogram			
	l. Other *(Specify)*			

SECTION II - COMMENTS ***(Explain any rating that is "Unacceptable".)***

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*